RESIDENTIAL ASSISTED LIVING FACILITY (RALF)
APPLICATION FOR FACILITY LICENSE IN IDAHO

PART A

Residential Assisted Living Facilities Program
Department of Health and Welfare
P.O. Box 83720 Boise, ID 83720-0009
Phone: (208) 364-1962
Fax: (208) 364-1888

Failure to provide all information as requested in Application Parts A and B for a license may result in the denial of the application (sections 16.03.22.110.05 and 940.02 of the rules).

PLEASE TYPE OR PRINT

I. GENERAL INFORMATION

a. Assisted Living Facility Name (*as registered with the Secretary of State – this is the DBA or ABN and is the name that will show on the license* – limit 55 characters)

b. Business Legal Name (if different from above):

c. Physical Street Address:	d. City (must be in Idaho):	e. Zip Code:
f. Mailing Street Address:	g. Mailing City and State:	h. Mailing Zip Code:
i. Facility Phone Number (include area code):	j. Facility Fax Number (include area code):	

k. Name, Phone Number and E-mail Address for Licensing and Certification Contacts:	l. Total Requested Bed Capacity:

m. Check One:

____ New Building
____ Change of Ownership/Licensed Entity.
Former Name: _____
____ Conversion (Existing building previously used for purpose other than RALF
____ Bed increase/decrease request. Number currently licensed for _____
____ Name Change only (no change in ownership)

n. Building Information: If facility has multiple buildings using building numbers and/or building name, outline below. Include campus map when submitting Part A

Bldg #	Building Name	#Beds
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

II. FACILITY LICENSURE INFORMATION

a. Date Proposed Facility Expects to Admit Residents:	b. Expected Date of Change of Ownership (if facility is already licensed):

c. Types of Residents to be Accepted:

☐ DEMENTIA ☐ DEVELOPMENTALLY DISABLED ☐ ELDERLY ☐ MENTALLY ILL ☐ PHYSICALLY DISABLED ☐ TRAUMATIC BRAIN INJURY

d. Adult day care services: ☐ NONE ☐ PRIVATE PAY ADULT HOURLY CARE ☐ MEDICAID ADULT DAY CARE

III. DISCLOSURE OF OWNERSHIP

OWNERSHIP: ***Name of all Individuals****, Organizations, Firms, Partnerships, Business Trusts, Corporations or Governmental Entities responsible for management of the facility. If facility is managed by a hierarchy of business entities,* ***Individual owners of each of those entities must also be disclosed.*** *Use Addendum A to provide additional disclosures for each sub-entity.*

a. Name:	b. Address:	c. Phone Number:	d. % Ownership:
1.			
2.			
3.			
4.			

Please continue on addendum A if this space is not adequate to list ***every entity and every individual with ownership of 10% or more.***

IV. MISCELLANEOUS INFORMATION

a. Minutes to Nearest Ambulance Service:	b. Minutes to Nearest Emergency Service:
c. Minutes to Nearest Hospital:	d. Minutes to Nearest Physician Service:

V. FACILITY FLOOR PLAN

ATTACH a copy of professionally prepared blueprints or a sketch of the floor plan (including measurements for all rooms). If the facility is new construction, consult with this office throughout the construction process to assure that the building meets all requirements.

VI. BUILDING EVALUATION

I request an initial building evaluation at the address identified in Section I(c-e).
The $500 check for the building evaluation is enclosed AS REQUIRED.

_____ _____
Signature of Applicant Date

VII. APPLICATION VERIFICATION

All owners having an interest of 10% or more in the facility MUST sign this application. BY SIGNING BELOW, I ACCEPT AND ACKNOWLEDGE THE FOLLOWING:

1) None of the owners or any person who will have control or influence in the operation of the facility:
   a. Have operated any health facility or residential care or assisted living facility without a license or a certified family home without a certificate (IDAPA 16.03.22.940.02.m.);
   b. Is of poor moral and responsible character or has been convicted of a felony or defrauding the government (IDAPA 16.03.22.940.02.o.);
   c. Has been denied a license or whose wrong-doing has caused the revocation of any license or certificate of any health facility, residential care or assisted living facility, or certified family home (IDAPA 16.03.22.940.02.l.);
   d. Has been convicted of a criminal offense other than a minor traffic violation in the past five (5) years (IDAPA 16.03.22.940.02.p.); or
   e. Has been guilty of fraud, gross negligence, abuse, assault, battery or exploitation with respect to the operation of a health facility, residential care or assisted living facility, or certified family home (IDAPA 16.03.22.940.02.h.).

2) I certify that the statements made in this application are true, complete, and correct;

3) I have read IDAPA 16.03.22, "Rules for Residential Care or Assisted Living Facilities in Idaho," and Idaho Code; Title 39, Chapter 33 “Idaho Residential or Assisted Living Act”, and will comply with all provisions of each;

4) I have read IDAPA 16.03.22.110.01.b and acknowledge that I have not been subject to any license revocation/disciplinary action against any license held previously or currently in Idaho or any other state or jurisdiction; and

5) The Administrator and each member of the organization who will provide direct resident care or will directly influence the facility’s operations is listed below and must sign this application in acknowledgment of items #3 and #4 above.

(“Direct Influence” means participation in decision making that affects the day to day operations of the facility. Such decisions include but are not limited to those regarding the hiring, firing or training of personnel; staffing levels; finance or budgets; resident rates for room, board and amenities, resident care and facility agreements; marketing; admission and retention of residents; management of the physical plant, and policies and procedures of the facility.)

Printed Name of Applicant	/	Signature of Applicant	Date	Date of Birth or SSN
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